Application for an Individual Health Contract for Simply Blue

P.O. Box 64024, St. Paul, MN 55164

FOR AGENT USE ONLY (Please print legibly)
Agency Code K 7
Agent's Number 1 3 4 8
Agent Name McAlpin Steve J.
Farm Bureau Employee Number

Applicant must be 90 days or older to apply.

1. Reason for Application:
   - ☐ New applicant not covered with BCBSM
   - ☐ Current BCBSM coverage: ID Number ______ ☐ Plan change
2. Applicant's name
   LAST FIRST MIDDLE
3. Applicant's Social Security # ___ - ___ - ___
4. Occupation
5. Date of Birth ___ - ___ - ___ (Month Day Year)
6. Sex ☐ Male ☐ Female
7. Marital Status ☐ Single ☐ Married
8. Applicant's address
   STREET APT#
   CITY STATE ZIP
9. Home phone # ______ Work phone # ______

10. SELECT YOUR CHOICE OF CALENDAR YEAR DEDUCTIBLE: ☐ $5,000 ☐ $7,500 ☐ $10,000
NOTE: Simply Blue provides benefits for prenatal care only and does not cover maternity-related services. Newborns or newly born children under 90 days old are not covered under the Individual Simply Blue contract. This is single coverage only, no dependents can be added to the contract.

11. Payment mode (check one): ☐ Annual (12 months) ☐ Semiannual (6 months) ☐ Quarterly (3 months) ☐ Pay-O-Matic (1 month)

Payment must accompany application. Amount paid with this application $ ______ If paying by check, please make your check payable to Blue Cross and Blue Shield of Minnesota (BCBSM). **We do not accept business checks or any other form of payment from a business for payment of coverage (See exception on page 4).**

12. **BEHAVIORAL HEALTH SUBSTANCE ABUSE COVERAGE:**
Coverage for substance abuse is included in the contract. You may choose to delete substance abuse coverage. Your premium will be slightly reduced if you delete substance abuse coverage.
Check this box if you want to **EXCLUDE** substance abuse coverage ☐

13. **TOBACCO USE DESIGNATION AND DECLARATION:**
I have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application ☐ **Yes** ☐ **No**

NOTE: tobacco-free rates are available only to persons who have not used tobacco and/or smokeless tobacco in the preceding 24 months.

14. **EFFECTIVE DATE:**
Have you completed an application for an Insta-Care contract to precede this coverage? ☐ **Yes** ☐ **No**
If **Yes**, please leave the requested effective date blank. We cannot process this application if the termination date of the Insta-Care contract is greater than 60 days beyond your signature date on this application.

It approved, coverage will be effective as of:

- the date that coincides with the termination date of the Insta-Care contract if you have applied for Insta-Care and we have received this completed application by that date, or
- the day the completed application is received by mail in the home office of BCBSM, or
- the day after the completed application is received in the home office of BCBSM if delivered to the lobby or submitted electronically, or
- a later effective date as requested here ___ - ___ - ___ (Month Day Year) (This date cannot be more than 60 days beyond the signature date.)

If this application is not approved, no coverage will be effective.

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15. **PREVIOUS HEALTH INSURANCE INFORMATION -** If you are approved for coverage, **your contract will not cover preexisting conditions for the first 12 months**. You will not be subject to this exclusion to the extent you have already fully satisfied this type of requirement under prior continuous coverage. Please provide details of other coverages below.

Do you currently have any health insurance or have you had any health insurance within the past 63 days? . . . . ☐ **Yes** ☐ **No**

If YES, you must fully complete the following section by providing all health insurance information for the past 12 months for yourself. Make sure to include information for other Blue Cross and Blue Shield of Minnesota coverages.

Insurance Company Name and Policy Number	Date Coverage Started month/day/year	Date Coverage Ended (If active, state active) month/day/year	Was the previous coverage individual or group coverage?
	/ /	/ /	
	/ /	/ /	

16. **COORDINATION OF BENEFITS - If the response is Yes, you may be contacted for more information.**
Will you have other health or medical coverage, including Medicare, once this policy is in force? . . . . ☐ **Yes** ☐ **No**

17. **Your Height:** _______ ft. _______ in. **Current Weight:** _______ lbs. **Weight One (1) Year Ago** _______ lbs.

18. **HEALTH HISTORY (Complete information is required)**
In the past five (5) years, have you had, been treated for or diagnosed as having diseases or disorders related to the following conditions? (Check each item either "Yes" or "No" and circle conditions.)

You do not have to disclose tests to detect the presence of human immune deficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), or other bloodborne pathogens which were administered to you at the time you were: (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) an emergency medical personnel who was tested as a result of performing emergency medical services while employed; (3) corrections employees or inmates; or (4) patients or employees of a secured facility. The term emergency medical personnel includes individuals employed to provide out of hospital medical emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as employees or volunteers of an ambulance service who provide emergency medical services; a member of an organized first responder squad that is formally recognized by a political subdivision in Minnesota; crime lab personnel; other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law; and any individual who, in the process of executing a citizen's arrest, may have experienced a significant exposure.

	Yes	No
A. HEART OR CIRCULATORY DISORDERS—Chest pain, rheumatic fever, heart murmur, stroke, high blood pressure, anemia, bleeding disorders, varicose veins, myocardial infarction or heart disease	☐	☐
B. GASTROINTESTINAL DISORDERS—Stomach, gallbladder, liver, intestinal bleeding or disorders, ulcers, hernia, hemorrhoids, chronic diarrhea, rectal disorders, or any treatment for obesity	☐	☐
C. GENITOURINARY DISORDERS—Kidney, urinary tract disorders, sexually transmitted diseases, infertility, disorders of the male reproductive system including prostate gland, disorders of the female reproductive system including menstrual disorders and abnormal pap smears	☐	☐
D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants	☐	☐
E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy or allergic reaction, lung, breathing disorder, or sleep apnea	☐	☐
F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, autism, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders	☐	☐
G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement	☐	☐
H. NEUROLOGICAL OR NEUROMUSCULAR DISORDERS—Headache or migraine, head injury, seizure disorder, multiple sclerosis, cerebral palsy, paralysis, or chronic fatigue syndrome	☐	☐
I. MUSCULOSKELETAL DISORDERS—Back disorders, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, osteoporosis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders, or amputation	☐	☐
J. TUMOR, CYST, OR POLYP	☐	☐
K. SKIN DISORDERS—Acne, rash, warts, or growth	☐	☐
L. COLLAGEN DISEASE—Lupus, scleroderma, or rheumatoid arthritis	☐	☐
M. GENERAL FATIGUE OR MALAISE, MONONUCLEOSIS, OR EPSTEIN-BARR SYNDROME	☐	☐
N. EYES, EARS, NOSE, THROAT DISORDERS—Impairment of sight, cataracts, eye muscle, otitis media, earache, hearing impairment, nasal or sinus disorders, tonsillitis, or adenoiditis	☐	☐
O. IMMUNE DISORDERS—Congenital or acquired disease or disorder of the immune system, including AIDS or an ARC (AIDS Related Complex)	☐	☐

	Yes	No
19. Have you ever had, been treated for or diagnosed as having cancer?	☐	☐

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	Yes	No
20. Female applicant: Are you pregnant?	☐	☐
21. Have you:		
A. Had a medical operation within the last five (5) years?	☐	☐
B. Been hospitalized within the last 10 years?	☐	☐
C. Seen a doctor, chiropractor, psychologist, therapist, or any other health care professional within the past five (5) years?	☐	☐
D. Received speech, physical, behavioral, or occupational therapy within the past five (5) years?	☐	☐
E. Ever had any positive test for or any disease or disorder of the immune system?	☐	☐
F. Had a health-related screening or diagnostic test such as a blood test, mammogram, x-ray, CT or MRI scan during the last five (5) years?	☐	☐
G. Ever been treated for or currently have a congenital abnormality?	☐	☐
22. Have you:		
A. In the past five (5) years, used drugs on a regular basis, other than drugs prescribed by a physician, or been treated for the abuse of any drugs or alcohol?	☐	☐
B. In the past five (5) years, have you been convicted of DWI or DUI or have you had your driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? If **Yes**, give details, including names, dates, and driver's license numbers in number 26.	☐	☐
C. In the past five (5) years, have you been medically advised by a health care professional to quit or reduce use of alcohol or drugs? If **Yes**, please provide details including individuals involved, dates, and driver's license number in number 26.	☐	☐
D. Do you drink alcohol? If **Yes**, please explain in number 26 the average amount used weekly.	☐	☐
23. Have you been advised by a health care professional to have evaluation, testing or treatment for a medical, dental, or mental health condition that has not yet been performed?	☐	☐
24. Have you ever been declined coverage, charged an increased rate, or had benefits excluded for health coverage?	☐	☐
25. Do you plan to travel in a foreign country in the next year?	☐	☐

If **Yes**,

Date of Departure	Destination	Date of Return

26. **IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS (18–24), PLEASE COMPLETE THIS SECTION. GIVE COMPLETE DETAILS. ADD AN ADDITIONAL PAGE IF YOU NEED MORE SPACE.**

Ques. no. & letter	Date of onset	Diagnosis, treatment, or **reason for physical check-up including all results of physical examinations and diagnostic tests**	Days in hospital	Date of complete recovery (If ongoing, state ongoing)	Doctor, Clinic or Hospital Name

	Yes	No
27. Have you taken any prescription medication within the past 24 months?	☐	☐

If **Yes:**

Drug Name and Dosage	Diagnosis	Dates Used	Doctor's Name

28. **PROVIDE NAMES OF THE PHYSICIANS/HEALTH CARE PROFESSIONALS WITH THE MOST COMPLETE KNOWLEDGE OF YOUR MEDICAL HISTORY:**

(Continued on page 4)

29. **TO BE SIGNED BY APPLICANT:**

I understand and agree that coverage, if approved, will commence with the effective date in accordance with question 14. I have included payment with this application. For administrative convenience, BCBSM will deposit in a bank any payment I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage. If this application is rejected, any money submitted will be refunded to me. When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment and you will not receive your check back from your financial institution.

In order to process your application, we may collect personal information regarding your health history and motor vehicle driving records from persons other than you. The information collected by us or our agents may in certain circumstances be disclosed to third parties without authorization. You have the right to see your personal records that are maintained by us and to correct personal information we have collected about you. Upon your request, we will furnish a more detailed notice of our information practices. The sole purpose for collecting this information is to underwrite your application for coverage.

I hereby authorize and request any hospital, clinic, institution, physician, pharmacy and pharmacy related service organizations or other person to furnish Blue Cross and Blue Shield of Minnesota full details of diagnosis, treatment, medical history, pharmaceutical records and any other information and conclusions about me and to accept as valid a photocopy of this authorization and my signature. We need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. We keep this information confidential, but may release it if you authorize release, or if State or Federal law permits or requires release without authorization. For claims purposes, this release is valid while you are enrolled in this health plan and until all claims are adjudicated following your termination of coverage. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid up to 26 months from the date you sign this application. You are entitled to receive a copy of this release. This authorization excludes the release of information about bloodborne pathogen tests that were administered to individuals described on page 2 of the application.

I have read the preceding statements and answers and declare them to be true and complete to the best of my knowledge and belief. I understand and agree BCBSM will act in reliance upon the information I have provided in this application and that any false information, omissions or misstatements in this application which materially affect either the acceptance of risk or hazard assumed by BCBSM may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment. I also understand and agree that payment of a claim does not preclude the right of the company to deny future claims or take any action it determines appropriate.

I agree to notify BCBSM immediately of any change in my health condition between the date of this application and the effective date of coverage. Failure to notify BCBSM of any change in my health condition may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment.

X ______________ X ______________________________ X ______________ X ______________________________

Date | Applicant's Signature | Date | Parent or Guarantor's Signature (if applicant is a minor)

As Parent or Guarantor, I understand that: (1) The applicant is the contractholder; (2) I guarantee payment to Blue Cross and Blue Shield of Minnesota; and (3) Any Blue Cross and Blue Shield of Minnesota issued payments will be made to the applicant or contractholder and not to me.

EXCEPTION FOR BUSINESS CHECKS OR OTHER FORMS OF PAYMENT FROM A BUSINESS

We do not accept business checks, Pay-O-Matic electronic payments, or any other form of payment from employers with two (2) or more individuals working 20 hours or more per week.

The only exception is if the business does not have two (2) or more individuals working 20 hours or more per week. If this exception applies to your application, you must sign and date the following statement:

I am paying for this coverage with a business check, Pay-O-Matic electronic payment, or other form of payment from a business. I confirm this business does not have two (2) or more individuals working 20 hours or more per week.

X ______________________________ X ______________________________

Date | Applicant's Signature

IF APPLICATION COMPLETED BY AGENT, COMPLETE AND SIGN BELOW

If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as provided by the applicant.

X ______________________________ ( ) ______________ ______________

Agent's Signature | Agent's Phone Number | Date

Pay-O-Matic is convenient!

You won't need to write a single check or buy a stamp. And there's no extra cost to you! Once a month, on your billing date, we'll deduct your payment directly from your bank or credit union account.

Attach a void check here with tape

DO NOT STAPLE

Getting started

1. **Complete the Pay-O-Matic authorization form.**
2. **Attach a void check if using a checking account.**
   Attach a savings deposit slip if using a savings account.
3. **Mail this form with your void check attached to the address shown.**

You can choose to stop Pay-O-Matic withdrawals and switch back to quarterly paper billing any time. Just let us know in writing **at least 15 days before your next withdrawal date** to allow for timely deactivation.

Pay-O-Matic
AUTHORIZATION FORM

I request and authorize Blue Cross and Blue Shield of Minnesota and Blue Plus to deduct my payment from my ☐ checking or ☐ savings account shown below.

Name on bank account ______________________________

Bank name ______________________________

Bank account number (attach a void check above) ______________________________

Branch office address ______________________________

City ____________________ State ______________ Zip ____________

FOR NEW CUSTOMERS: If you are sending this authorization along with an application for coverage, please enclose a check for one month's payment. If you are already a customer, do not send money.

Blue Cross or Blue Plus has the right to end this authorization by sending written notice to my current address as shown in Blue Cross or Blue Plus records.

I understand that this authorization may be stopped by notifying Blue Cross or Blue Plus **at least 15 days before my account is to be charged for the next payment.** I also understand that only the amount of the payment deducted by Blue Cross or Blue Plus will be repaid to me by check after notification in accordance with these instructions.

Name of applicant/member (please print) ______________________________

Applicant/member's social security number ______________________________

X ______________________________ Date ____________
Signature of account holder

X ______________________________ Date ____________
Signature of account holder (if joint account)

Important information if using a business account ...

We do not accept Pay-O-Matic electronic payments from employers with two (2) or more individuals working 20 hours or more per week. If your electronic payment will come from a business account, you must sign the following statement:

I am paying for this coverage with a Pay-O-Matic electronic payment from a business account. I confirm this business does not have two (2) or more individuals working 20 hours or more per week.

Signature ______________________________ Date ____________

MAIL TO: Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, St. Paul, MN 55164-0560